MANAGEMENT & CONFIDENTIAL WELLNESS/FITNESS BENEFIT
CLAIM FOR REIMBURSEMENT

EMPLOYEE:_____ DEPT: _____
(print name)

I am requesting reimbursement for the following expenses in accordance with the Management & Confidential Wellness/Fitness Benefit:

PLEASE CHECK ONE:

☐ Medical Examination/Laboratory Tests
☐ Weight Control/Counseling Program
☐ Smoking Cessation Program
☐ Physical Fitness/Wellness Activity
(Stress Management, Municipal Recreation Program)
☐ Gym/Fitness Provider

Name of Provider: _____

Amount to be Reimbursed: $_____

Attach to this claim form either an <u>original</u> receipt or a copy of a cancelled check which evidences payment.

MINIMUM CLAIM AMOUNT ACCEPTED IS $10.00.

MAXIMUM AMOUNT REIMBURSED PER PROGRAM YEAR IS $200.00.

A MAXIMUM OF FOUR (4) CLAIMS PER PROGRAM YEAR WILL BE ACCEPTED.

ONLY SERVICES RECEIVED WITHIN THE PROGRAM YEAR WILL BE REIMBURSED. THEREFORE, CLAIMS SHOWING GYM/FITNESS MEMBERSHIPS EXTENDING BEYOND THE PROGRAM YEAR WILL BE PRORATED. THE PROGRAM YEAR FOR 2010 IS JAN. 1 - DEC. 31, 2010

CLAIMS FOR 2010 EXPENSES MUST BE SUBMITTED BEFORE MARCH 1, 2011.

I, the undersigned declare, that all statements made on this form are true and correct to the best of my knowledge. I understand that I will be taxed on all amounts reimbursed to me under this Wellness Benefit, with the exception of physical examination-related expenses.

Signed:_____ ID #: _____ Date: _____

Send claim form to Risk Management

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FOR RISK MANAGEMENT ONLY

Claim approved/denied on _____ for $_____ by_____

Record created _____